

# PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.  
The information provided is important to your dental health.

Patient's name \_\_\_\_\_ Preferred name \_\_\_\_\_ Birth date \_\_\_\_\_  
If minor, parents names \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Spouse's name \_\_\_\_\_ Spouse's employer \_\_\_\_\_  Unmarried  
Whom may we thank for referring you to our office? \_\_\_\_\_  Phonebook

**BILLING, CREDIT, AND INSURANCE INFORMATION:**  Not covered by dental insurance  
Your Social Security number: \_\_\_\_\_ Dental Insurance Co. \_\_\_\_\_ Group number \_\_\_\_\_  
Covered by spouse's insurance?  yes  no  
Spouse's dental insurance company \_\_\_\_\_ Group number \_\_\_\_\_  
Spouse's birthday \_\_\_\_\_ Social Security number \_\_\_\_\_

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?  
(Please check any that apply)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco?  yes  no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: \_\_\_\_\_

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: \_\_\_\_\_

Women:

- May be pregnant  
Expected delivery date: \_\_\_\_\_
- Taking hormones or contraceptives

Name of your physician: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above? \_\_\_\_\_

Please add anything else you would like us to know about: \_\_\_\_\_

Signature of patient (or parent) \_\_\_\_\_ Date \_\_\_\_\_